SUMTER COUNTY BOARD OF COUNTY COMMISSIONERS
SELF-FUNDED EMPLOYEE
MEDICAL, PHARMACY AND DENTAL BENEFIT PLAN
SUMMARY OF BENEFITS

ALL BENEFITS ARE EFFECTIVE OCTOBER 1, 2003 WITH THE EXCEPTION OF THE CALENDAR YEAR DEDUCTIBLES AND OUT-OF-POCKET MAXIMUMS, BOTH OF WHICH ARE EFFECTIVE JANUARY 1, 2003.
UPDATE 10/1/2008

LIFETIME MAXIMUM	**$1,500,000 PER PERSON**
DEDUCTIBLE PER CALENDAR YEAR ***In or Out of Network***	
Per Covered Individual	$300 Per Person
Per Family (2 deductibles per family)	$600 Per Family
OUT-OF-POCKET MAXIMUM PER CALENDAR YEAR ***In or Out of Network*** ***Does not include Deductibles or Co-payments***	
Per Covered Individual	$1,500 Per Person
Per Family (2 deductibles per family)	$3,000 Per Family

The Plan will pay the designated percentage of covered charges until the Out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of covered charges for the rest of the Calendar Year unless stated otherwise. Calendar Year Deductible(s) and co-payments do not apply toward the Out-of-Pocket maximum and are not reimbursable. The Deductible and Out-of-Pocket Maximum is the same for In-Network or Out-of-Network Providers and will be combined to accumulate to the total due.

COVERED SERVICES	IN-NETWORK	OUT-OF NETWORK
OFFICE VISITS Includes all services rendered during the office visit, including surgical procedures and X-rays.	$20 Co-payment (family Dr, General Practitioner, Internal Medicine & Pediatrician)) $35 Co-payment (Specialist)	70% After Deductible
Chiropractic Care *$5,000 PCY Max applies to Chiropractic/Spinal Manipulations (26 PCY), physical/massage, occupational, speech, and cardiac therapy (4 modalities per day)*	$35 Co-payment (Specialist)	70% After Deductible
Outpatient Diagnostic Testing, *EKG and other neurological and cardiovascular tests*	90% After Deductible	70% After Deductible
Independent Clinical Laboratories *Blood and urine tests*	90% Deductible Waived	70% Deductible Waived
Well Baby Care & Immunizations (Post hospital to 16 years-limited to specific ages)	$20 Co-payment (family Dr, General Practitioner, Internal Medicine & Pediatrician) $35 Co-payment (Specialist)	70% Deductible Waived

Routine Mammograms *One every two years ages 40-49 and once a year after age 50.* *Mammograms do not accumulate towards Adult Wellness Care*	100% Deductible Waived	70% Deductible Waived
Adult Wellness Care *Up to $150 max per calendar year (age 17 and over)* ***Services may include but not limited to evaluation and management services, pap smear, prostate specific antigen, cholesterol screening, complete blood count, urinalysis, fecal occult blood and immunizations. Services do not include treatment or diagnosis related to vision or hearing.***	$20 Co-payment (family Dr, General Practitioner, Internal Medicine) $35 Co-payment (Specialist)	70% Deductible Waived
HOSPITAL SERVICES	**IN-NETWORK**	**OUT-OF NETWORK**
Hospital Inpatient Services	90% after Deductible	70% After Deductible and $300 Per Admission Deductible
Hospital or Other Surgical Facility For Out-Patient Surgery	90% After Deductible	70% After Deductible
Hospital or Other Facility for Major Diagnostic Tests (MRI, CT Scan, etc.)	90% after Deductible	70% After Deductible
Surgeon and Anesthesia Outpatient Fees	90% After Deductible	70% After Deductible
Emergency Room Care (Co-payment waived if an accident or applied to the Inpatient Hospital Deductible if admitted) Drs. May be sub-contracted & not under contract with Blue Cross	90% After Deductible	70% After Deductible
Accident Care *Not subject to CYD, subject to coinsurance, no max.* *Benefits apply only to emergency room or office services for accidents, if admitted benefits are payable under medical services.*	90% Deductible Waived	90% Deductible Waived
OTHER SERVICES	**IN-NETWORK**	**OUT-OF NETWORK**
Physical, Occupational or Speech Therapy per Calendar Year *$5,000 PCY Max applies to Chiropractic/Spinal Manipulations (26 PCY), physical/massage, occupational, speech, and cardiac therapy (4 modalities per day)*	$35 Co-payment (Specialist) 90% after Deductible if rendered at Outpatient Facility	70% After Deductible

Major Durable Medical Equipment	90% After Deductible	70% After Deductible
Skilled Nursing/Extended Care Facility *120 Days Maximum Per Calendar Year*	90% After Deductible	70% After Deductible
Home Health Care *$5,000 PCY max.* *No visit max.*	90% After Deductible	70% After Deductible
Hospice Care- Inpatient or Outpatient *$15,000 Lifetime Maximum Combined Inpatient and Outpatient*	90% After Deductible	70% After Deductible
Organ Transplant *Covered transplants: Bone Marrow, corneal, heart, heart-lung, liver, kidney, pancreas, kidney-pancreas and lung*	90% After Deductible	70% After Deductible
Other Covered Medical Expenses	90% After Deductible	70% After Deductible
MENTAL OR NERVOUS DISORDERS	**IN-NETWORK**	**OUT-OF NETWORK**
Mental Health-Inpatient **30 Days Maximum Per Calendar Year**	90% After Deductible	70% After Deductible
Mental Health-Outpatient **30 Visits Maximum Per Calendar Year**	$35 Co-payment (Specialist)	70% After Deductible
SUBSTANCE ABUSE OR CHEMICAL DEPENDENCY	**IN-NETWORK**	**OUT-OF NETWORK**
Inpatient *No visit max.*	90% After Deductible	70% After Deductible
Outpatient *No visit max.*	$35 Co-payment (Specialist)	70% After Deductible
Inpatient and Outpatient Lifetime Maximum	$10,000	$10,000
PRESCRIPTION DRUGS	**IN-NETWORK**	**OUT-OF NETWORK**
Network Pharmacy *One month supply* *Oral Contraceptives and devices Covered* ***Includes Mail Order Prescriptions at 2X retail copay for 90 day supply***	**$5 Co-Payment Generic** **$25 Co-Payment Preferred-Brand** **$50 Co-Payment Non-Preferred Brand**	*Applicable copay plus 20%*

DENTAL COVERAGE		
Deductible	\$50 per person per calendar year	
Deductible does not apply to Class I Preventive Services		
Calendar Year Maximum (per person)	\$1,500 per person	
Orthodontic Lifetime Maximum (per person)	\$1,500 per person	
Benefits	**IN-NETWORK**	**OUT-OF-NETWORK**
Class I - Preventive Services	**100%**	**100%**
oral examinations, routine cleanings, radiographs and fluoride treatments		
Class II - Basic Services	**80%**	**80%**
fillings, root canals, periodontal treatment, and oral surgery		
Class III - Major Services	**50%**	**50%**
crowns, bridges, partials and dentures		
Class IV- Orthodontic Services *(Child only to age 19)*	**50%**	**50%**
• *In-Network benefits are payable based on the Plan's PPO Area Schedule for services provided by a contracted dentist.*		
• *Out-of-Network benefits are payable for services rendered by a dentist who is not a participating provider. Reimbursements are based on the 90th percentile of reasonable and customary charges.*		
• *In-Network Orthodontic Providers provide a 20% discount of their usual & reasonable fees*		